DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900-AR01

VA Pilot Program on Graduate Medical Education and Residency

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) adopts as final, with changes, a proposed rule amending its medical regulations to establish a new pilot program on graduate medical education and residency, as required by section 403 of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Network Act of 2018.

DATES: This rule is effective [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE *FEDERAL REGISTER*].

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SUPPLEMENTARY INFORMATION:

On February 4, 2022, VA published a proposed rule in the Federal Register (87 FR 6456) to revise its medical regulations to establish the Pilot Program on Graduate Medical Education and Residency (PPGMER) in §§ 17.243 through 17.248 of title 38, Code of Federal Regulations (CFR). The proposed rule provided a framework to establish additional medical residency positions at certain covered facilities, consistent with the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Network Act of 2018 (the Act), Public Law (Pub. L.) 115-182. Section 403 of the Act, codified as a note to section 7302

of title 38 United States Code (U.S.C.), establishes parameters for VA to determine the covered facilities in which residents will be placed (including prioritization of certain covered facilities such as those operated by an Indian Tribe or tribal organization), and authorizes VA to pay resident stipends and benefits as well as certain startup costs of new residency programs when residents are placed in such programs. VA provided a 60-day comment period.

On March 25, 2022, prior to the end of the 60-day comment period, VA published a second proposed rule (87 FR 17050) to extend the comment period by 90 days to end on July 5, 2022, to ensure tribal stakeholders were aware of the proposed rule and had sufficient time to provide meaningful input. On March 30, 2022, VA sent a letter to tribal leaders and tribal health program leadership to inform them of the rulemaking and to provide information for a virtual information session for tribal leaders on April 19, 2022, and a virtual tribal consultation on May 10, 2022. The transcripts from those events are available as part of this rulemaking docket on *www.regulations.gov*.

VA received 19 comments on the proposed rule from four large professional medical organizations, six tribes and tribal organizations, and numerous members of the public. All 19 comments were supportive of the rule, and we thank the commenters for their thoughtful and detailed feedback. We address the substantive recommendations and clarify certain aspects about the program below. We adopt the proposed rule as final with two substantive changes and one minor technical change as described in more detail below.

§ 17.243 – Purpose and Scope

Section 17.243, as proposed, provided a broad overview of the authority for the PPGMER as well as general description of the function and scope of the PPGMER. One commenter recommended revising § 17.243 to include a description from the regulatory impact analysis that accompanied the proposed rule of the “numerous

benefits the program will offer to both veterans and non-veterans" and the explanation of how the PPGMER will "fulfill the VA's broader missions." The commenter stated that including this information in the purpose and scope at 38 CFR 17.243 would "strengthen the VA's argument for both the compelling need and the statutory authority of this regulation." Because the purpose and scope section is a broad overview of the authority for the PPGMER, not a detailed explanation of the many benefits it may provide, we make no changes to the rule based on this comment.

§ 17.245 – Covered Facilities

Section 17.245, as proposed, listed the covered facilities in which residents may be placed under the PPGMER, consistent with section 403(a)(2) of the Act. Multiple commenters recommended VA add additional facilities to the covered facilities explicitly listed in § 17.245. In particular, they suggested the inclusion of Rural Health Clinics, rural training sites, "non-VA facilities with ACGME-accredited GME programs in non-contiguous areas," Urban Indian Organization facilities, and consortia of Indian Health Service, Tribal, and Urban Indian Organization ("I/T/U") facilities. The commenters stated that the inclusion of these additional covered facilities would improve access to health care for either underserved populations and/or individuals in rural locations.

We make no changes to the rule based on these comments. As proposed, the language in §17.245(f) already allows VA to consider those types of facilities as covered facilities for the purposes of the PPGMER. The language proposed by VA to describe the six categories of covered facilities in §17.245(a) through (f) is almost identical to the language Congress used to describe the covered facilities in section 403(a)(2)(A) through (F) of the Act. The first five paragraphs of both the statute and the regulation enumerate five specific categories of health care facilities that are considered covered facilities for purposes of the PPGMER. Both authorities then provide a sixth and final

category allowing VA to consider any other health care facilities deemed by VA to be appropriate for participation.

As stated in the proposed rule, the language of 38 CFR 17.245(f) provides VA the ability to place residents in a variety of facilities without curtailing the discretion given to VA in section 403(a)(2)(F) of the Act. Explicitly listing the five facilities suggested by the commenters as additional covered facilities in 38 CFR 17.245 does not provide additional flexibility beyond what is provided in paragraph (f). VA intends to use the inclusive authority of paragraph (f) to the maximum extent possible, which will allow for potential resident placements at all facilities meeting the intent of the pilot program; we do not anticipate placing limitations on which facilities may be considered. Therefore, further specificity in the regulation does not substantively impact whether these five additional categories of facilities may be deemed appropriate covered facilities by VA.

Placement of Residents

Prior to addressing certain comments on proposed §§ 17.246 through 17.248 that concern the placement of residents under the PPGMER, we first clarify VA's role in such placements under both its traditional graduate medical education (GME) programming and the new PPGMER. In administering traditional GME programming, VA forms relationships with non-VA institutions that sponsor GME programs (most often medical schools or teaching hospitals), and it is those sponsoring institutions that provide the residents that would be available for placement in VA facilities. The same would be true for the PPGMER.

VA, therefore, does not control the pool of participating educational programs or available residents, although VA does assess the requirements for traditional GME placements under 3 U.S.C. 7302(e) to determine the best placement locations for such residents in VA facilities, and VA will do similarly for the PPGMER in accordance with

the provisions in 38 CFR 17.246 and 17.247. VA in effect then does not place residents but does provide for resident positions to be filled in VA facilities under its traditional GME programming and will similarly provide for resident positions to be filled in covered facilities as defined in § 17.245 under the PPGMER.

§ 17.246(a) – Placement of Residents

Section 17.246, as proposed, established factors that VA would consider when determining in which covered facilities residents would be placed under the pilot, consistent with section 403(a)(4) of the Act. We received multiple comments requesting modifications and additions to the consideration factors for placement of residents found in 38 CFR 17.246(a). Paragraphs (a)(1) through (6) of § 17.246 enumerate six specific factors VA will consider in determining the clinical need for health care providers before determining resident placements. These six factors use almost identical language to the language used in section 403(a)(4)(A) through (G) of the Act. Additionally, the final factor listed in 38 CFR 17.246(a)(7) gives VA the ability to consider any other criteria important in determining which covered facilities are not adequately serving area veterans, consistent with section 403(a)(4)(G) of the Act.

We considered each comment related to 38 CFR 17.246(a) and address each individually below. However, we make no changes to 38 CFR 17.246(a) due to the flexibility provided in paragraph (a)(7), which equips VA to consider all other important criteria not otherwise specifically listed in paragraphs (a)(1) through (a)(6) when determining resident placement (and further provides a non-exhaustive list of such other criteria as examples in (a)(7)(i) and (ii)). VA intends to use the broad consideration permitted by paragraph (a)(7), along with the six specific factors in paragraphs (a)(1) through (6), to ensure that every covered entity submitting a proposal for resident placement receives consideration to the maximum extent authorized by section 403(a)(4) of the Act.

§ 17.246(a)(1). One commenter recommended that the term “general practitioners and specialists” be changed to “primary care physicians and other specialists.” This commenter also requested that, when determining the ratio of veterans to VA providers under this paragraph, VA calculate separate ratios for internal medicine and for family medicine. The commenter stated that the term “primary care physicians and specialists” would be inclusive of family medicine practitioners who provide women’s health care and young adult care and are well-positioned to serve the entire veteran population, while internal medicine focuses exclusively on adult medicine. We do not make changes based on this comment. We believe the term “general practitioners” captures the category of “primary care physicians” suggested by the commenter, and further, we would not want to unduly restrict consideration only to “primary care physicians,” which would be in conflict with the clear language of the statute as stated in section 403(a)(4)(A) of the Act. We also do not believe that further distinguishing the ratios of primary care providers between internal medicine and family medicine will have a significant impact on the success of the PPGMER, although any important criteria related to these distinctions may be considered under 38 CFR 17.246(a)(7).

§ 17.246(a)(1)(i). Two commenters expressed concern with VA’s decision to use “county” to define a “standardized geographic area” for the placement factors enumerated in § 17.246(a)(1) and (2). One commenter believed that using “county” as the standard would not account for “truly remote areas such as non-contiguous states.” This commenter did not offer a recommendation for an alternate standard, but emphasized that Hawaii has unique healthcare challenges in a non-contiguous area with a high population of Native Hawaiians and Pacific Islanders and would like VA to include them to the extent authorized by law. Another commenter asked VA to apply a standard similar to the one used to designate a health professional shortage area

(HPSA) under 42 U.S.C. 254e(a)(1), “which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services,” as justification for removing the requirement to rely on geographic area based on county in this paragraph.

VA believes that a “county” can both account for truly remote areas and serve as a “rational area for the delivery of health services” in line with the standard established in 42 U.S.C. 254e(a)(1). Further, a “county” is a simple standard in the context of § 17.246(a)(1) and (2) to provide clarity to covered facilities submitting proposals as well as to VA in evaluating proposals. As stated in the proposed rule, the factors in 38 CFR 17.246(a)(1) and (2) that use the “county” standard are only two of six enumerated factors VA will consider in determining the clinical need for health care providers in an area. VA may therefore consider all other important criteria using the authority in paragraph (a)(7) to ensure consideration of these commenters’ concerns, to include being in a non-contiguous State. We make no change to the rule based on these comments.

§ 17.246(a)(3). One commenter requested that VA “draw upon a combination of resources beyond the OIG [Office of Inspector General] report” to assess whether the specialty of a provider is included in the most recent staffing shortage determination in 38 CFR 17.246(a)(3). We make no changes to the rule based on this comment. The language used in the regulation for this factor is almost identical to the language in section 403(a)(4)(C) of the Act. Additionally, the OIG report has consistently been the manner in which VA determines its yearly staffing shortages and we have no reason to believe this data will be insufficient. VA may further consider all other important criteria using the authority of 38 CFR 17.246(a)(7), including any relevant information derived from sources beyond the OIG report.

§ 17.246(a)(5). One commenter stated that HPSA designations may not be an adequate measure of the clinical need for health care providers in a non-contiguous area. The commenter specifically requested that VA use its authority under section 403(a)(4)(G) of the Act to grant special allowance for non-contiguous areas to be considered as an important criterion for determining resident placement. We make no change to the rule based on this comment. The HPSA standard used in 38 CFR 17.246(a)(5) is directed by section 403(a)(4)(E) of the Act. However, as mentioned previously, 38 CFR 17.246(a)(7) provides VA the ability to consider the unique situation of all covered facilities submitting proposals, including the clinical need for health care providers in a non-contiguous area. The HPSA standard in § 17.246(a)(7) will not limit VA's ability to consider non-contiguous areas when determining resident placement.

Additional Specific Criteria. Two commenters suggested VA add additional consideration factors when determining the placement of residents. One commenter recommended that VA explicitly include "the accessibility of gender and sexual orientation services" to the "other criteria" in § 17.246(a)(7). Another commenter recommended we add "availability of culturally sensitive healthcare options" and "ongoing healthcare shortages at a covered facility." Because these factors may be considered using the authority in 38 CFR 17.246(a)(7), we make no changes to the rule to explicitly include them.

§ 17.246(b) – Priority in Placements

Consistent with section 403(a)(5) of the Act, § 17.246(b), as proposed, established that there would be a prioritized placement of at least 100 residents under the PPGMER. In the proposed rule, we clarified that VA would interpret the term "residents" to refer to the unique, individual physicians participating in the PPGMER and would not interpret the term "residents" to refer to each individual residency position (or "slot") in which an individual physician participating in the PPGMER would be placed.

We further explained that multiple PPGMER participants could occupy a single residency position while individually counting toward the priority placement mandate. Multiple commenters expressed disagreement with our proposed interpretation, stating VA should interpret "residents" to mean "residency positions" and should aim to place more than 100 individual physicians into these priority placements. The commenters expressed concern that VA's interpretation in the proposed rule was indicative of VA's intention only to place 100 individual physicians and no more.

We make no changes to the rule based on these comments. The term "resident" is commonly understood as a reference to a unique, individual person in the medical context, as Merriam-Webster defines "resident" (in the medical context) to mean a physician serving a residency. See Merriam-Webster Dictionary Online, "resident," *www.merriam-webster.com*. This definition aligns with VA's interpretation that in the medical context, "resident" refers to the individual physician participating in a residency program. As we noted in the proposed rule, interpreting "residents" to refer to the unique, individual physicians participating in the PPGMER, not the residency positions themselves, is also consistent with a plain reading of section 403(a)(5) of the Act. That plain reading, both on its own and when using the aforementioned medical definition of "resident", supports VA's decision to consider priority placement of "no fewer than 100 residents," not 100 resident positions. Counting the unique, individual physicians who are placed in covered facilities given priority is the most logical way to ensure we meet Congressional intent.

We emphasize that we do not interpret anything in section 403 of the Act nor this rulemaking to limit how many unique, individual physicians may serve in covered facilities given priority in placements. That is, VA may exceed the minimum requirement for priority in placements in the PPGMER.

We received a related comment requesting that VA "reserve" a minimum of ten percent of resident positions created by the PPGMER for Indian Health Service and tribal health care facilities. We make no change to the rule based on this comment. As an initial matter, it is unclear from the comment whether the ten percent would be ten percent of the minimum 100 residents placed in prioritized facilities under section 403(a)(5) of the Act, or ten percent of the total resident positions created by the PPGMER. Regardless, we do not read any authority in section 403 of the Act allowing VA to reserve a percentage of residents for a particular covered facility. Subsection (a)(5) is the sole provision in section 403 of the Act related to prioritization of resident placement in particular covered facilities. While it does not expressly require VA to reserve any percentage of resident placement to Indian Health Service and tribal care facilities, we note that three of the four enumerated categories of covered facilities in which no fewer than 100 residents must be placed are those operated by the Indian Health Service, an Indian tribe, or a tribal organization.

We further believe that regulating additional criteria in § 17.246(b) to place no fewer than 100 residents under section 403(a)(5) the Act would be arbitrary and unnecessarily restrictive because the need for residents among the four types of prioritized facilities could shift over the life of the PPGMER, and VA's selection of facilities for resident placement will be based on information VA receives pursuant to the request for proposal (where that information will vary each cycle that VA issues the request for proposal).

§ 17.246 – Weighting of Factors

Section 17.246, as proposed, did not specify any particular weighting of consideration factors for placement of residents under the PPGMER. We received multiple comments stating VA should specify the weighting to be given to each consideration factor for placement of residents. Some commenters believed that VA

should be transparent about how it will weigh factors and another commenter stated that VA's decision directly contradicts Congressional intent to give priority to placements in covered facilities operated by the Indian Health Service, an Indian Tribe, a tribal organization, or located in communities designated as undeserved. We make no changes based on these comments. The consideration factors and priority in placements listed in § 17.246 are a restating of the factors listed in section 403(a)(4) and (5) of the Act, and section 403 of the Act does not otherwise establish any weighting of the factors. As stated in the proposed rule, weighting is not further included in the regulatory text itself so that VA maintains flexibility to adjust the relative importance of each consideration factor throughout the duration of the PPGMER. Consistent with 38 CFR 17.247(a)(1), each request for proposal will describe the specific consideration factors that will be used to evaluate responses, along with the relative importance of each factor.

Because this is a pilot program, it is imperative that VA retain the ability to make crucial changes from year to year, addressing the outcome and lessons learned from prior resident placements and accounting for any changes in the medical and educational landscape. The decision not to include weighting in the regulation ensures VA can fully meet the intent of the PPGMER.

§ 17.247 – Request for Proposal

Section 17.247, as proposed, stated that a request for proposal (RFP) would be issued by VA Central Office to VA health care facilities announcing opportunities for residents to be placed in covered facilities and to have costs paid or reimbursed in accordance with § 17.248. The proposed rule further stated that VA health care facilities, in collaboration with covered facilities, would submit responses to the RFP directly to VA Central Office. Multiple commenters stated that establishing a process where the RFP is issued directly to VA health care facilities, and subsequently

entrusting those facilities to announce the RFP and collect responses from potential covered facilities, could prevent consideration of facilities that do not currently have an affiliate relationship with VA. The commenters recommended that VA publicly announce the RFP and allow proposals to be submitted directly by covered facilities.

We agree that the RFP process contemplated in the proposed rule could limit VA's ability to reach the facilities intended for participation the PPGMER. Therefore, we will change proposed § 17.247(a), which states that "VA Central Office will issue a request for proposal (RFP) to VA health care facilities to announce opportunities for residents to be placed in covered facilities and to have costs paid or reimbursed under § 17.248" and remove the phrase "to VA health care facilities," so the sentence states that "VA Central Office will issue a request for proposal (RFP) to announce opportunities for residents to be placed in covered facilities and to have costs paid or reimbursed under § 17.248." This change will ensure there is no limitation on how VA Central Office may issue the RFP.

We make two similar changes to clarify that covered facilities will submit responses to the RFP directly to VA Central Office. We will change proposed § 17.247(b), which states that "VA health care facilities, in collaboration with covered facilities, will submit responses to the RFP to VA Central Office" and remove the phrase "VA health care facilities, in collaboration with" so the paragraph states that "covered facilities will submit responses to the RFP to VA Central Office." We also change proposed paragraph (c), which states that "consistent with paragraph (a) of this section, VA Central Office will evaluate responses to the RFP from VA health care facilities and will determine those covered facilities where residents may be placed and costs under § 17.248 are paid or reimbursed" and remove the phrase "from VA health care facilities" so it states, "consistent with paragraph (a) of this section, VA Central Office will evaluate

responses to the RFP and will determine those covered facilities where residents may be placed and costs under § 17.248 are paid or reimbursed."

These changes to § 17.247 ensure that all potential covered facilities may be considered for participation in the PPGMER and alleviate any burden on VA health care facilities to serve as an intermediary to announce, collect, and submit responses to the RFP to VA Central Office. VA believes these changes to the RFP process address the commenters' concerns, meet the intent of the PPGMER to reach underserved areas, and clarify that the PPGMER is not a public funding opportunity or grant program.

§ 17.248 – Costs

Section 403(a)(6) of the Act authorizes VA to pay the proportionate cost of stipends and benefits for residents participating in the PPGMER. In addition to stipends and benefits, if a covered facility establishes a new residency program and is selected for PPGMER participation, section 403(b) of the Act authorizes VA to reimburse certain initial costs associated with establishing that program. The statutory provisions related to these costs are codified and further clarified in 38 CFR 17.248.

Multiple commenters requested that VA amend the regulation to allow covered facilities with established residency programs to be eligible for reimbursement of costs associated with program operation. Specifically, these commenters requested VA cover expenses such as incremental costs for additional residents or slots, costs associated with expanding an existing GME program, costs for a "wide range of necessities" in operating residency programs, and costs that support tribes in attracting high quality providers (and setting aside a tribal allocation for this purpose).

We make no change to the rule based on these comments. The statutory authority is clear—unlike section 403(a)(2)(F) and (a)(4)(G), which provide VA the authority to consider "such other" covered facilities and consideration criteria when determining resident placements, the cost provisions in section 403(a)(6) and (b) of the

Act are finite. Congress has not authorized VA to expand payment or reimbursement of costs beyond those expenses specifically enumerated in statute.

Additionally, one commenter suggested that VA offer scholarships to residents participating in the PPGMER. We do not believe VA has authority under section 403 of the Act to offer any type of PPGMER-specific scholarship to residents placed under the PPGMER. PPGMER costs related to support of residents (as opposed to support of new residency programs) are provided in section 403(a)(6) of the Act, which limits payments to only stipends and benefits for residents placed under the PPGMER program.

Additionally, one commenter provided recommendations for how VA should execute funding principles during administration of the PPGMER. Although these suggestions are administrative in nature and do not directly impact the regulation, we address each to provide further information to stakeholders. The commenter suggested VA should fund actual costs, rather than a predetermined amount per resident; should make awards of no less than five years in duration; and should allow participation in any other Federal GME program if no costs were duplicated among the funding agencies. While not specifically stated, we believe these recommendations are related to the reimbursable expenses permitted for new residency programs in accordance with 17.248(b)(1) (since the commenter stated these expenses are “above and beyond” the stipends and benefits permitted under 17.248(a)). First, section 403(b) of the Act provides specific and limited authority for the types of expenses that can be reimbursed under the PPGMER. VA will treat the PPGMER equitably with its existing GME programming and will not exceed VA’s established maximum amounts for these types of payments under any existing GME agreements. Second, the authority for the PPGMER ends in 2031, which would provide a very limited window to make awards no less than five years in duration. Finally, participation in the PPGMER will not preclude

participating in other Federal GME programs provided no costs are duplicated among the funding agencies. We make no changes based on these comments.

Reporting and Evaluation

Multiple commenters provided input related to the reporting requirement contained in section 403(c) of the Act requiring VA to provide yearly reports to Congress on the implementation of the PPGMER. While these reports will be submitted by VA directly to Congress, the data used to compile these reports must be collected by the covered facilities and residents participating in the PPGMER.

One commenter requested that VA ensure that reporting requirements are not burdensome and only include data required by section 403(c) of the Act. Two commenters requested that VA explicitly include any reporting requirements in regulation, and one of those commenters also requested that VA outline how it will store the collected data. One commenter further requested that VA include three questions for evaluation of the pilot program in the final regulation, specifically: (1) was the PPGMER successful in accomplishing a predetermined goal; (2) does the PPGMER provide increased access for veterans to comprehensive primary care and needed specialty care; and (3) are the physicians trained under the PPGMER continuing to provide access to veterans after training, and in areas of greatest need? We thank these commenters for their feedback, but we make no changes to the rule based on these comments. VA intends to collect only the data explicitly required by section 403(c) of the Act and will provide those statutory requirements in the RFP, which is in line with the commenter's suggestion to only request data required by section 403(c) of the Act and would not be more burdensome than required. VA will not include additional questions evaluating the PPGMER in regulation, as it would be unnecessary. The aim of the Paperwork Reduction Act (PRA) is to reduce the total amount of paperwork burden the Federal government imposes on private businesses and citizens, and VA

does not want to add any additional burden when we do not believe the commenter's suggested questions would provide additional value in evaluating the PPGMER. VA will use only the reporting requirements stated in the Act. Additionally, VA will not provide information on data storage in regulation because requirements for the handling of Federal records are contained in 36 CFR chapter XII, subchapter B, parts 1220 through 1234, and further detailed in VA Directive 6300, Records Information and Management (September 21, 2018). Further information on data collection and the estimated paperwork burden for the PPGMER is outlined in the PRA section of this rulemaking.

Additionally, one commenter pointed out that VA did not outline a plan for data collection in the proposed rulemaking. After publication of the proposed rule, VA published a Federal Register notice detailing the information collection related to this rulemaking. See 87 FR 65852 (November 1, 2022). That Federal Register notice is available as part of this rulemaking docket on *www.regulations.gov*.

Impact Analysis

One commenter provided extensive feedback on the regulatory impact analysis (RIA) associated with the rulemaking. Much of the commenter's input focused on the methodology and costing used to formulate the RIA, and did not relate to the regulatory framework proposed by VA. However, the commenter stated that the RIA provided information on the benefits of the PPGMER and how it will fulfill VA's broader mission, which should be included in the purpose and scope in 38 CFR 17.243. We thank the commenter for this feedback but make no changes to the rule. It would be unnecessary to describe the PPGMER's potential benefits in regulation, and VA will keep the purpose and scope focused on the framework of the rulemaking. Regarding the commenter's input on the RIA itself, the RIA details the anticipated need for rulemaking and sets out the assumptions and methodology used to determine the estimated financial impact of

the PPGMER and the associated rulemaking. This estimate was created using regular VA business practices for its current GME programming.

Clarifications

We received multiple comments that we believe warrant clarification. Most importantly, multiple comments urged VA to conduct a tribal consultation prior to publishing a final rule. As mentioned at the beginning of this rulemaking, VA extended the public comment period by 90 days in order to conduct both an information session with tribal leaders and a full tribal consultation as required by VA policy and Executive Order 13175. We received comments from six tribes and tribal organizations, and all of the input we received was carefully considered as part of this final rulemaking.

Many commenters seemed to have a general misunderstanding that the PPGMER was focused on increasing access to medical care for veterans specifically. We reiterate that the focus of this program is on the placement of residents who will provide medical care, not on the specific demographics of the individuals who will receive medical care from such residents. Neither the regulation nor section 403 of the Act contain any criteria or curtailments regarding the individuals eligible to receive medical care from residents participating in the PPGMER.

While 38 CFR 17.245(a) allows for resident placements at a VA health care facility consistent with section 403(a)(2)(A) of the Act, we do not anticipate using the PPGMER to supplement the resident positions permanently authorized under VA's existing GME authority. Instead, we intend to prioritize placements at non-VA facilities outlined in 38 CFR 17.245(b) through (f). While we believe it is possible that a veteran could end up receiving medical care from a resident participating in the PPGMER, we imagine this situation would occur at a non-VA facility and involve a veteran eligible for health care through another (non-VA) source.

Additionally, some comments indicated a misunderstanding that VA is involved in the actual selection and placement process of individual residents for participation in the PPGMER. One commenter stated that VA should clarify how residents are selected for participation, one commenter requested VA fill positions with rural and American Indian/Alaska Native residents, and one commenter provided recommendations for how to better incentivize participation in the program.

As stated in the proposed rule, residents apply to and are hired directly by GME institutions, which are most often medical schools or teaching hospitals. VA forms relationships with non-VA institutions sponsoring GME programs, and it is those sponsoring institutions that will provide residents to participate in the PPGMER. VA does not select residents for its GME programming authorized under 38 U.S.C. 7302, and VA will not deviate from that process in the administration of the PPGMER. While VA maintains an affiliate relationship with certain GME institutions, placement of residents at VA and non-VA facilities lies solely within the discretion of the affiliate institution, not VA. Once VA has selected the covered entities where residents will be placed, those affiliate institutions will select individual residents to fill those PPGMER resident positions.

One commenter provided multiple recommendations related to the actual substance of the training residents participating in the PPGMER will receive. Consistent with section 403 of the Act, the regulation mentions training only in reference to the standard medical educational process and in referencing certain reimbursable costs for new residency programs. Because the substantive training of residents is beyond the scope of this rulemaking, we do not specifically address these comments.

One commenter asked for clarification as to what VA considers “medically underserved.” VA must consider five or more factors under section 401 of the Act, one of which is “whether the local community is medically underserved.” Under 38 CFR

17.246(a)(4), VA will consider whether the local community of a covered entity is designated as “underserved,” and both the statute and the regulation state that VA will make the “underserved” determination using criteria developed under section 401 of the Act. The determination of whether a VA facility is underserved is led by VA’s Partnered Evidence-Based Policy Resource Center (PEPReC). Each year PEPReC, in coordination with VA’s Office of Veterans Access to Care and various program offices, uses intricate statistical modeling to generate a list of potentially underserved VA facilities to help local and national leaders provide better access to care for veterans. Further detailed information on the methodology and model variables used to make this determination is available on PEPReC’s website at *www.peprec.research.va.gov* under “Our Projects.”

Other Comments

We received multiple comments requesting VA take certain actions in conjunction with the PPGMER. While these comments are not within the scope of the rulemaking itself, we want to acknowledge and briefly address the thoughtful input provided by the commenters. We note that while these comments are administrative in nature, they could be appropriate for inclusion in a covered facility’s proposal.

We received multiple comments urging VA to support residency programs at covered facilities already in existence, to include tribal-affiliated residency programs. We make no changes based on these comments. While there is no preference for existing programs over new programs in the regulation or in section 403 of the Act, we believe existing residency programs at covered facilities will be strong candidates for PPGMER resident placements, and tribal-affiliated covered facilities will receive priority in placements under 38 CFR 17.246(b).

One commenter urged VA to consider how we can provide long-term support for small and new residency programs after completion of the pilot program. We make no

changes based on this comment. Once the pilot concludes, VA may only rely on its existing GME authority to fund resident salary and benefits for residents placed in VA facilities. Certain additional costs, such as VA's share of accreditation fees, may be reimbursed using an Educational Cost Contract between VA and the sponsoring institution. However, the authority in section 403 of the Act is not intended to provide "long-term support" as suggested by the commenter.

One commenter suggested VA collaborate with IHS and tribal health facilities directly to "determine specialty specific needs for medical residents" to better serve tribes, and another commenter suggested VA engage the VA Advisory Committee on Tribal and Indian Affairs to develop and implement the PPGMER, especially the reimbursement mechanism. We make no changes based on these comments. VA plans to work through its Office of Tribal and Government Relations (OTGR) and the VA Advisory Committee on Tribal and Indian Affairs to ensure widest dissemination of the RFP to tribal stakeholders, including IHS and tribal health facilities.

One commenter urged VA to "consider recent successes in residency programs at urban facilities as an indicator of the need and impact residency programs have in urban AI/AN [American Indian/Alaska Native] communities." Another commenter requested VA collaborate directly with and increase funding to GME programs with high rates of AI/AN graduates. We make no changes based on these comments. VA will use the statutory criteria to prioritize locations for resident placements under 38 CFR 17.246(b), which would include urban AI/AN facilities operated by IHS, an Indian tribe, or a tribal organization.

One commenter wanted VA to provide specific guidance on how rural communities will be targeted, and another commenter similarly urged VA to expand the pilot in ways that will support the training of more physicians in rural communities. We make no changes based on these comments. VA will use the statutory criteria to

prioritize locations for resident placements under 38 CFR 17.246(b), which would include facilities located in the same areas as VA facilities designated as underserved under 38 CFR 17.246(b).

Finally, one commenter requested that VA provide a public report to inform future policymaking. The commenter suggested that the report contain information about the PPGMER such as the VA health care facilities that submitted proposals, the covered facilities chosen for resident placements, the participating GME affiliates, and the specialties of residents participating in the PPGMER. We make no changes based on this comment. VA intends to make certain PPGMER information available on the Office of Academic Affiliations website (*www.va.gov/oaa*).

Change Not Based on Comments

VA makes one minor technical change to the definition of "VA health care facility" in 38 CFR 17.244 to remove the capitalization of "Veteran," changing the term to "veteran." This change maintains consistency of the term's usage throughout these and other VA regulations.

Executive Orders 12866, 13563, and 14094

Executive Order 12866 (Regulatory Planning and Review) directs agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 14094 (Executive Order on Modernizing Regulatory Review) supplements and reaffirms the principles, structures, and definitions governing contemporary regulatory review established in Executive Order 12866 of September 30,

1993 (Regulatory Planning and Review), and Executive Order 13563 of January 18, 2011 (Improving Regulation and Regulatory Review). The Office of Information and Regulatory Affairs has determined that this rulemaking is a significant regulatory action under Executive Order 12866**,** as amended by Executive Order 14094. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *www.regulations.gov*.

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (5 U.S.C. 601 through 612). The residents who will be placed in covered facilities and have certain stipends and benefits paid for by VA are individuals and not small entities. To the extent that any covered facilities are small entities, there is no significant economic impact because the rulemaking only permits VA's reimbursement of certain start-up costs associated with new residency programs. Additionally, there is no funding opportunity for which covered facilities may apply to be considered and otherwise no economic gain or loss for covered facilities associated with this rule. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and Tribal Governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and Tribal Governments, or on the private sector.

Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (44 U.S.C. 3507) requires that VA consider the impact of paperwork and other information collection burdens imposed on the public. According to the implementing regulations for the Paperwork Reduction Act (5 CFR 1320.8(b)(2)(vi)), an agency may not collect or sponsor the collection of information, nor may it impose an information collection requirement, unless it displays a currently valid Office of Management and Budget (OMB) control number.

This rule includes provisions constituting collections of information under the Paperwork Reduction Act of 1995 that require approval by OMB. Accordingly, pursuant to 44 U.S.C. 3507(d), VA is submitting a copy of this rulemaking action to OMB for review. The proposed rule did not include a PRA notice, and the 60-day notice was published separately in the Federal Register on November 1, 2022 (Vol. 87, No. 210, pages 65852-65853). VA did not receive any public comments on the proposed information collection in response to this notice. OMB assigns control numbers to collections of information it approves. VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. If OMB does not approve the collection of information as requested, VA will immediately remove the provisions containing a collection of information or take such other action as is directed by OMB.

Participants in the PPGMER must collect and provide VA with certain programmatic data to enable VA to report to Congress on the pilot program, as required by statute, until the program terminates on August 7, 2031. This information would be collected by the residents placed in covered facilities under the PPGMER and their GME sponsoring institutions. The sponsors themselves will determine the best method for collection of the necessary data depending on their own resources and staffing. The information to be collected will include required elements, such as number of patients

seen per day by each resident placed in a covered facility under the PPGMER, for the annual report on the pilot program submitted to Congress by VA.

Title: Physician Resident Data Collection.

- *Summary of collection of information:* This collection of information is used to determine the number of patients seen by physician residents each day/month under the PPGMER, pursuant to § 17.243. The information would be collected by residents placed in covered facilities under the PPGMER.
- *Description of the need for information and proposed use of information:* This information is needed to calculate the total number patients seen by residents placed in covered facilities under the PPGMER.
- *Description of likely respondents:* Participating residents.
- *Estimated number of respondents per year:* 100.
- *Estimated frequency of responses per year:* 1 time per year.
- *Estimated average burden per response:* 6 hours.
- *Estimated total annual reporting and recordkeeping burden:* 600 hours.
- *Total estimated cost to respondents per year:* VA estimates the total annual cost to respondents will be $23,006. The mean hourly wage for a resident is $38.34 (for data collection). The estimated wage information was taken from VA's internal data systems, using average salary data for physician residents in post-graduate years 1 to 3.

Title: GME Sponsor Annual Data Consolidation.

- *Summary of collection of information:* This collection of information is used to consolidate physician resident data and compile an annual report to Congress, pursuant to § 17.243. The GME sponsoring institutions will collect the data and provide it to VA for inclusion in the report to Congress.

- *Description of the need for information and proposed use of information:* This information is needed to provide data for the annual report to Congress.
- *Description of likely respondents:* GME sponsoring institutions.
- *Estimated number of respondents per year:* 10.
- *Estimated frequency of responses per year:* 1 time per year.
- *Estimated average burden per response:* 120 hours.
- *Estimated total annual reporting and recordkeeping burden:* 1200 hours.
- *Total estimated cost to respondents per year:* VA estimates the total annual cost to respondents will be $30,708. The mean hourly wage for a health information technologist is $25.59 (for data consolidation and reporting). The estimated wage information was taken from the Bureau of Labor Statistics from the following website: *https://www.bls.gov/oes/current/oes_nat.htm*.

Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq*.), the Office of Information and Regulatory Affairs designated this rule as not a major rule, as defined by 5 U.S.C. 804(2).

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Colleges and universities, Education, Government contracts, Health care, Health facilities, Health professions, Indians, Medical and dental schools, Reporting and recordkeeping requirements, Scholarships and fellowships, Schools, Veterans.

Signing Authority:

Denis McDonough, Secretary of Veterans Affairs, signed and approved this document on September 14, 2023, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Luvenia Potts,

Regulation Development Coordinator

Office of Regulation Policy & Management,

Office of General Counsel,

Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs amends 38 CFR part 17 as follows:

PART 17 – MEDICAL

1. Amend the authority citation for part 17 by adding an entry for §§ 17.243 through 17.248 in numerical order to read in part as follows:

Authority: 38 U.S.C. 501, and as noted in specific sections.

* * * * *

Sections 17.243 through 17.248 are also issued under 38 U.S.C. 7302 note.

* * * * *

2. Add an undesignated center heading and §§ 17.243 through 17.248 to read as follows:

VA Pilot Program on Graduate Medical Education and Residency

§ 17.243 Purpose and scope.

(a) *Purpose*. This section and §§ 17.244 through 17.248 implement the VA Pilot Program on Graduate Medical Education and Residency (PPGMER), which permits placement of residents in existing or new residency programs in covered facilities and permits VA to reimburse certain costs associated with establishing new residency programs in covered facilities, as authorized by section 403 of Public Law 115-182.

(b) *Scope*. This section and §§ 17.244 through 17.248 apply only to the PPGMER as authorized under section 403 of Public Law 115-182, and not to VA's more

general administration of graduate medical residency programs in VA facilities as authorized under 38 U.S.C. 7302(e).

§ 17.244 Definitions.

For purposes of §§ 17.243 through 17.248:

Benefit means a benefit provided by VA to a resident that has monetary value in addition to a resident's stipend, which may include but not be limited to health insurance, life insurance, worker's compensation, disability insurance, Federal Insurance Contributions Act taxes, and retirement contributions.

Covered facility means any facility identified in § 17.245.

Educational activities mean all activities in which residents participate to meet educational goals or curriculum requirements of a residency program, to include but not be limited to: clinical duties; research; attendance in didactic sessions; attendance at facility committee meetings; scholarly activities that are part of an accredited training program; and approved educational details.

Resident means physician trainees engaged in post-graduate specialty or subspecialty training programs that are either accredited by the Accreditation Council for Graduate Medical Education or in the application process for such accreditation. A resident may include an individual in their first post-graduate year (PGY-1) of training (often referred to as an intern), and an individual who has completed training in their primary specialty and continues training in a subspecialty graduate medical education program (generally referred to a fellow).

Stipend means the annual salary paid by VA for a resident.

VA health care facility means any VA-owned or VA-operated location where VA physicians provide care to veterans, to include but not be limited to a VA medical center, independent outpatient clinic, domiciliary, nursing home (community living center), residential treatment program, and community-based clinic.

§ 17.245 Covered facilities.

A covered facility is any of the following:

(a) A VA health care facility;

(b) A health care facility operated by an Indian tribe or tribal organization, as those terms are defined in 25 U.S.C. 5304 and at 25 CFR 273.106;

(c) A health care facility operated by the Indian Health Service;

(d) A federally-qualified health center as defined in 42 U.S.C. 1396d(l)(2)(B);

(e) A health care facility operated by the Department of Defense; or

(f) Other health care facilities deemed appropriate by VA.

§ 17.246 Consideration factors for placement of residents.

(a) *General*. When determining in which covered facilities residents will be placed, VA shall consider the clinical need for health care providers in an area, as determined by VA's evaluation of the following factors:

(1) The ratio of veterans to VA providers for a standardized geographic area surrounding a covered facility, including a separate ratio for general practitioners and specialists.

(i) For purposes of paragraphs (a)(1) and (2) of this section, standardized geographic area means the county in which the covered facility is located.

(ii) VA may consider either or both of the ratio(s) for general practitioners and specialists, where a higher ratio of veterans to VA providers indicates a higher need for health care providers in an area.

(2) The range of clinical specialties of VA and non-VA providers for a standardized geographic area surrounding a covered facility, where the presence of fewer clinical specialties indicates a higher need for health care providers in an area.

(3) Whether the specialty of a provider is included in the most recent staffing shortage determination by VA under 38 U.S.C. 7412.

(4) Whether the covered facility is in the local community of a VA facility that has been designated by VA as an underserved facility pursuant to criteria developed under section 401 of Public Law 115-182.

(5) Whether the covered facility is located in a community that is designated by the Secretary of Health and Human Services as a health professional shortage area under 42 U.S.C. 254e.

(6) Whether the covered facility is in a rural or remote area, where:

(i) A rural area means an area identified by the U.S. Census Bureau as rural; and

(ii) A remote area means an area within a zip-code designated as a frontier and remote area (FAR) code by the Economic Research Service within the United States Department of Agriculture, based on the most recent decennial census and to include all identified FAR code levels.

(7) Such other criteria as VA considers important in determining those covered facilities that are not adequately serving area veterans. These factors may include but are not limited to:

(i) Proximity of a non-VA covered facility to a VA health care facility, such that residents placed in non-VA covered facilities may also receive training in VA health care facilities.

(ii) Programmatic considerations related to establishing or maintaining a sustainable residency program, such as: whether the stated objectives of a residency program align with VA's workforce needs; the likely or known available educational infrastructure of a new residency program or existing residency program (including the ability to attract and retain qualified teaching faculty); and the ability of the residency program to remain financially sustainable after the cessation of funding that VA may furnish under § 17.248.

(b) *Priority in placements*. For the duration in which the PPGMER is administered, no fewer than 100 residents will be placed in covered facilities operated by either the Indian Health Service, an Indian tribe, a tribal organization, or covered facilities located in the same areas as VA facilities designated by VA as underserved pursuant to criteria developed under section 401 of Public Law 115-182.

§ 17.247 Determination process for placement of residents.

Section 403 of Public Law 115-182 does not authorize a grant program or cooperative agreement program through which covered facilities or any other entity may apply for residents to be placed in covered facilities or to apply for VA to pay or reimburse costs under § 17.248. VA therefore will not conduct a public solicitation to determine those covered facilities in which residents may be placed or to determine costs that may be paid or reimbursed under § 17.248. VA will instead determine those covered facilities in which residents may be placed and determine any costs to be paid or reimbursed under § 17.248 in accordance with the following parameters:

(a) VA Central Office will issue a request for proposal (RFP) to announce opportunities for residents to be placed in covered facilities and to have costs paid or reimbursed under § 17.248. This RFP will describe, at a minimum:

(1) Consideration factors to include the criteria in § 17.246, that will be used to evaluate any responses to the RFP, as well as the relative importance of such consideration factors;

(2) Information required to be in any responses to the RFP; and

(3) The process to submit a response to the RFP.

(b) Covered facilities will submit responses to the RFP to VA Central Office.

(c) Consistent with paragraph (a) of this section, VA Central Office will evaluate responses to the RFP and will determine those covered facilities where residents may be placed and costs under § 17.248 are paid or reimbursed.

§ 17.248 Costs of placing residents and new residency programs.

Once VA determines in which covered facilities residents will be placed in accordance with §§ 17.246 through 17.247, payment or reimbursement is authorized for the following costs:

(a) *Resident stipends and benefits*. For residents placed in covered facilities, VA may pay only the proportionate cost of resident stipends and benefits that are associated with residents participating in educational activities directly related to the PPGMER, in accordance with any contract, agreement, or other arrangement VA has legal authority to form.

(b) *Costs associated with new residency programs*. (1) If a covered facility establishes a new residency program in which a resident is placed, VA will reimburse the following costs in accordance with any contract, agreement, or other arrangement VA has legal authority to form.

(i) Curriculum development costs, to include but not be limited to costs associated with needs analysis, didactic activities, materials, equipment, consultant fees, and instructional design.

(ii) Recruitment and retention of faculty costs, to include but not be limited to costs associated with advertising available faculty positions, and monetary incentives to fill such positions such as relocation costs and educational loan repayment.

(iii) Accreditation costs, to include but not be limited to the administrative fees incurred by a covered facility in association with applying for only initial accreditation of the program by the Accreditation Council for Graduate Medical Education (ACGME).

(iv) Faculty salary costs, to include only the proportionate cost of faculty performing duties directly related to the PPGMER.

(v) Resident education expense costs, to include but not be limited to costs associated with the required purchase of medical equipment and required training,

national resident match program participation fees, and residency program management software fees.

(2) VA considers new residency programs as only those residency programs that have initial ACGME accreditation or have continued ACGME accreditation without outcomes, and have not graduated an inaugural class, at the time VA has determined those covered facilities where residents will be placed under § 17.247(c).

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